DEPARTMENT OF HEALTH SERVICES
DIVISION OF DRINKING WATER AND ENVIRONMENTAL MANAGEMENT
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SDWSRF
Overview-Guidance
MBE/WBE
Quarterly Utilization Report Completion
July 2001

Part 1.

1A. Federal Fiscal Year (FFY) [Note that FFY runs from October though September of the following year] Please **complete or modify as necessary.**

1B. Reporting Quarter (check box) [Note that this relates to quarter sequence of the FFY.] **Please complete as necessary.**

2A. Submit Report to: (as indicated, this report should be send to California Department of Health Services, SDWSRF office in Sacramento via mail, email, or fax) (This report substitutes for the analogous USEPA form.)

2B. State's Contact/Phone number: As indicated.

3A. Loan Recipient's Name and Address: **please complete as appropriate**.

3B. SRF Loan No.: As indicated.

3C. Recipient's contact/phone number: **please complete as appropriate; please include email address if available.**

4A. Period when contracts and/or purchases under this project will occur: [Total period of this funding agreement (typically 3 years from loan contract signing). Period may be extended back to project start date at recipients discretion.] **Please complete as appropriate**.

4B. Amount of total project dollars planned for contracts and/or purchases this quarter: [Estimate of claims for reimbursement planned for this quarter]. **Please complete as appropriate.**

4C. Recipient's MBE/WBE Goals (Percent of total dollars in 4B for each). [Option 1: Attach the letter of USEPA to California DHS identifying the 8 distinct goals for construction, equipment, supplies, and services for MBE and WBE. Option 2: put in the goals for construction for MBE and WBE from the referenced letter.] **Please complete as appropriate.**

5A. Actual amount of project dollars expended for contracts and purchases this quarter. [Does not reference the dates in which the work occurred.] Do not include in-house (force account) expenses of the recipient**. Please complete to reflect the claims for reimbursement submitted to the Department of Health Services during the reporting quarter.**

5B. Actual amount of MBE/WBE contracts and/or purchases accomplished this quarter from part II [Aggregate of payments to MBE and WBE firms as reflected in claims for reimbursement to Department of Health Services for the reporting quarter.] **Please complete to reflect the MBE/WBE component of claims for reimbursement for this quarter, consistent with the detail provided in Part II.**

6. Negative report. (Check box) **Please complete if this is a "negative" ($0.00 to MBE/WBE) report for reporting quarter.**
Comments: **Please provide comments as necessary.**
Name of Recipient's Authorized Representative: **Please provide name of person completing report.**
Title: **Please provide title of person completing report.**
Signature: **Please provide signature of person completing report**
Date: **Please provide date report completed.**